Department of Health and Mental Hygiene
Community and Family Health Administrations
M00F02

Response to Issues

Issue 1. Is Maryland Prepared for a Pandemic Influenza? (pages 17-19)
The Community Health Administration should be prepared to discuss the status of the State's pandemic preparedness efforts, including the status of surge capacity and the development of vaccine and antiviral supply, distribution, and mass immunization strategies. Furthermore, the department should be prepared to comment on what needs remain and how they will be addressed.

Response:
The Department's formal pandemic influenza preparedness planning activities began in February 1999 with a small federal grant. The Department acted immediately to enlist MEMA and MIEMSS as partners. Initial efforts focused on promoting awareness of the need for advance planning and sought to secure buy-in from a wide variety of organizations in the public and private sectors.

Maryland was one of the first states to develop its own pandemic influenza response plan. In March 2000 a draft of the initial Maryland Pandemic Influenza Preparedness Plan was prepared based on interim guidance received from the federal Centers for Disease Control and Prevention (CDC). Following the consideration of comments solicited from a wide array of partners and stakeholders, a revised finalized Plan was issued two years later. The current draft pandemic influenza response plan is available at www.edcp.org.

Since federal Health Resources and Services Administration funding became available in 2002, funds have been used to develop surge capacity and surge capability for isolation in acute and specialty hospitals, community health centers and large group practices. DHMH leads the statewide planning and preparedness efforts for treatment of large numbers of acutely ill patients including inpatient and outpatient facilities. Maryland hospitals have prepared for a surge capacity of approximately 7,000 beds over usual capacity. Within this number are several hundred beds that can provide respiratory isolation. In a related matter, DHMH was instrumental in the establishment of an interagency Health and Medical Surge Technical Advisory Group (TAG) to address health system needs for large numbers of acutely ill and injured patients. One planning scenario is pandemic influenza. The TAG is charged with writing an integrative, Statewide, system-wide plan, with a target completion date of August 2006.

DHMH has conducted several pandemic influenza tabletop exercises, including one for several other State agencies and local health departments (April 2004) and one focused on issues related to schools (August 2005). Two major intrastate regions have conducted exercises that address leveraging local resources to treat large numbers of acutely ill patients. DHMH representatives have participated in several CDC and Council of State and Territorial Epidemiologists' national pandemic influenza preparedness planning efforts.

A “mid-level” pandemic might be expected to infect ~1.3 million Marylanders and lead to 44,500 hospitalizations and 10,000 deaths – all over a several month period. Major aspects of preparedness and response can be divided into the following activities: early detection/surveillance; vaccination; antiviral medication use; other prevention and control measures.

Early Detection/Surveillance of AI/Pandemic Influenza

- DHMH has provided guidance about which patients to test for human AI, H5N1 and other potential pandemic strains to local health departments, MD acute care hospitals, and other healthcare providers, focusing on:
    - Persons who were in Asia within 10 days of illness onset
    - Poultry workers
    - Certain healthcare workers hospitalized with pneumonia
- The DHMH Laboratories Administration does screening PCR testing for H5N1 and other possible AI and pandemic strains; all positive screening tests are sent to CDC for confirmatory testing
- The existing Maryland Influenza surveillance systems will be enhanced in response to AI/pandemic influenza to monitor influenza activity; however, except possibly in the earliest stages of a pandemic, there would be no need to identify every case of influenza that occurred in Maryland

Vaccination

- Vaccine, the cornerstone of influenza prevention, would likely not be available during the initial phases of a pandemic
- No licensed vaccine against H5N1 or any other possible pandemic strains is currently available
- H5N1 vaccine currently undergoing clinical trials, including here in MD
- Even if licensed, it would be difficult to produce needed amounts of vaccine quickly enough – influenza vaccine production relies on old, time-consuming techniques
- Federal DHHS is working to develop and maintain a national stockpile of this H5N1 vaccine; no state has such a stockpile
- No guarantee that H5N1 would be the pandemic strain; if not, this vaccine potentially produced and purchased in vain
- Federal DHHS is attempting to develop national consensus on prioritization for vaccine use, should it be available in limited amounts; DHMH prepared to disseminate these recommendations and assist with interpretation and practical implementation
- Currently, ~ 90% of influenza vaccine is distributed through private sector
- Local health departments are developing capacity to distribute vaccines and medications quickly in a crisis; though it’s possible that during a pandemic, flu vaccine may not be available quickly, but in small amounts distributed over several months. Local health departments operate seasonal flu clinics each year that provide an opportunity to vaccinate large numbers of people, and have conducted exercises ranging from full-scale to tabletop to practice the distribution of vaccines and other medications under simulated crisis conditions.

Antiviral Medication Use

- Lacking vaccine, antiviral medications might play a limited role in treatment and potentially, prevention of pandemic influenza; however
- Current supplies of antivirals are insufficient to play a major role during a pandemic; therefore use would need to be targeted to have greatest benefit
- Federal DHHS currently coordinating development of consensus around how to use limited supply of antivirals during a pandemic; DHMH prepared to disseminate these recommendations and assist with interpretation and practical implementation
- Oseltamavir (Tamiflu) currently available in limited supplies from federal Strategic National Stockpile
- In conjunction with MIEMSS, DHMH can quickly inventory state healthcare facility supplies of antivirals and assist with redistribution as necessary

Other Prevention and Control Measures

- Simple disease prevention measures like handwashing and cough hygiene may actually be very important in controlling a pandemic, and DHMH has an inventory of hygiene education materials available for deployment
- The utility of widespread surgical mask use during a pandemic is not known; however, mask use will likely be reasonable for limited situations
- Quarantine of non-ill but potentially exposed persons WILL NOT likely be useful, except potentially in the very early phases of a pandemic; however
  - Other “community containment measures” WILL likely be important, such as school closures (DHMH-Schools tabletop exercise, August 2005)
  - “Snow Days”
  - Cancellation of large public gatherings
- Legal authorities for these types of measures exist; DHMH is developing further guidance on practical implementation
- DHMH has already provided infection control recommendations to local health departments and to MD acute care hospital infection control professionals

What We Still Need

- Government-wide planning for continuation of operations and maintenance of essential services if 25-35% of employees are absent during an 8-week (or longer) period
- Private sector planning for continuation of operations and maintenance of essential services if 25-35% of employees are absent during an 8-week (or longer) period
- More refined assessment of local public health and healthcare system capacity to respond to an influenza pandemic (using existing assessment tools)
- Support for existing healthcare system surge capacity/pandemic influenza planning and promotion of economic/market means to achieve goals
- Refined health department methods for vaccinating target priority groups in the face of vaccine shortages and demand for vaccine by groups not considered “priority”
- Further refined systems to coordinate distribution of vaccine or antivirals through the private sector, should that distribution system be employed by the federal government

- A small stockpile of antiviral medications for special situations (like for prophylaxis of poultry eradication workers if AI is identified in Maryland birds)
- Enhancements to existing public-private disaster response system to provide comprehensive assistance to persons, including ill persons, in their homes
- Support for research and development of new influenza vaccines and influenza vaccine technologies (US as a whole; possibly MD)
- Support for research and development of new antiviral medications (US as a whole; possibly MD)
- Enhancements to the existing influenza sentinel provider surveillance network and other influenza surveillance systems
- Refined "community containment measures" recommendations (e.g., refined recommendations for surgical mask use)
- Enhanced surge capacity for the DHMH Laboratories Administration to maintain the ability to identify AI and/or pandemic influenza during the course of a pandemic
- MDA may need more guidance from USDA related to preventing bird AI in MD
- Plans to monitor for the spread of AI H5N1 to Maryland via migratory wild birds
- Improved education of public and private decision makers about pandemic influenza. The first step in this process was the Pandemic Flu Summit held February 24, 2006.
- Local assessments of public and private health resources that could be available in response to anticipated increased demands for services during an influenza pandemic
- Completion and pre-positioning of pandemic-related public awareness materials and educational materials about recognizing influenza; preventing influenza transmission; preparing for a pandemic; home care when appropriate; quarantine measures if ordered by local health authorities
- Review of State emergency operations plan to assure full integration of pandemic flu plans into Maryland all hazards' planning

Issue 2. Breast and Cervical Cancer Screening Program Costs (pages 19-23)
The Family Health Administration should comment on the differences between the services provided and program costs. The administration should also comment on how the UMMG's breast and cervical cancer screening program will screen an additional 600 women in fiscal 2006 despite approximately the same clinical budget as fiscal 2005.

Response:
The services provided by the breast and cervical cancer programs at the UMMG and Medstar vary. The Breast and Cervical Cancer Program at the UMMG is funded with special funds under the Cigarette Restitution Fund Program, while the program at Medstar is funded with state and federal funds. The statutory requirements, structure, and complexity of these funding sources are different, so the services provided by these two programs are also different. For example, the UMMG must establish and maintain a Baltimore City Cancer Coalition; Medstar does not have this requirement. The UMMG provides extensive education and outreach to Baltimore City residents; Medstar has very limited funding for outreach. UMMG provides funds for treatment services; Medstar does not. The UMMG hosts a cancer survivor network and support group; Medstar does not. The UMMG screens individuals through a network of federally qualified health centers; Medstar provides screening services through two hospital sites. Each program

reimburses medical providers for breast and cervical cancer screening services at the approved Medicare rate, so the actual costs for each screening test (e.g mammogram) is similar. The difference in other program costs is a reflection of the different non-screening services provided by each program.

The UMMG estimates that it will be able to screen an additional 600 women in FY 2006 through the increase ($13,809) in the budget for clinical services and by re-allocating funding for screening services within its budget.

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Response to Recommended Actions

Recommendation 1.
Adopt budget language that prohibits the expenditure of Cigarette Restitution Funds until legal proceedings related to the 2006 Master Settlement Agreement payment are concluded.

Response:
The Department disagrees with the recommendation for three reasons.

1. The proposed language would create a deficit of $26 million in Medicaid that is not funded. This is contrary to efforts to produce a balanced budget.
2. The total amount of Cigarette Restitution Funds that Maryland is expecting to receive in fiscal 2006 is $123,605,000, as reported on Appendix M in the State budget. The difference from the $153,478,000 amount is the legal settlement fees, funds that are not received by Maryland State government.
3. The language would withhold $26 million in Medicaid funding unless the State receives the full amount of Cigarette Restitution Funds reported in the budget. This could result in a Medicaid reduction that is out of proportion to the loss of funds, assuming the Cigarette Restitution Fund receipts fall slightly below the amount stipulated. In other words, assuming the amount required is correctly reported as $123,605,000 in the budget language, failing to attain that level of funding by $1 could trigger a loss of funds in Medicaid of $26,000,000.

The Department believes the Cigarette Restitution Funds should be appropriated as requested in the budget allowance. In the event that Cigarette Restitution Fund receipts are less than reported in the budget, the Governor will take action to balance the budget, as has been done in previous years.

Recommendation 2.
Reduce funding for contractual employees. The allowance of $800,784 for contractual salaries exceeds the actual fiscal 2005 spending by $225,324. In each of the last three years, the administration has received more than $2.5 million to hire contractual employees and spent less than $1.8 million for that purpose. The reduction still allows for a 20% increase over actual fiscal 2005 spending.

Total Reductions: $110,232
General Fund Reductions: $40,103
Special Fund Reductions: $5,450
Federal Fund Reductions: $64,679

Response:
The Department disagrees with the recommendation to reduce funding for contractual employees. Contractual employees are needed to fulfill programmatic obligations in a number of

critical public health programs. For example, contractual staff are needed to carry out bill paying functions within the Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment Program. Another example of an important public health program with contractual staff needs is the Universal Newborn Hearing Screening Program. Eliminating funding for these contractual positions will not eliminate the need for their services, but instead will lead to an increased reliance on temporary agency and other help that will exceed the savings from the original cost containment measure.

Community and Family Health Administrations Fiscal 2007 Budget Overview

Maryland Department of Health and Mental Hygiene

February - March 2006

Revised 2/14/06

Community Health Administration (CHA) *Overview*

- Created in July 2001, the Community Health Administration was established to:
  - Provide a more focused, responsive, and accountable public health infrastructure for protecting the health of Maryland's communities
    - Disease outbreak investigation
    - Food protection and consumer health services
    - Environmental health
  - Better meet the needs of local health departments (LHDs)
    - Assessment and planning assistance
    - Liaison to other DHMH units
    - Core public health services
  - Strengthen the Department's capacity for addressing bioterrorism and emergency preparedness
    - Lead public health preparedness planning & response
    - Provide guidance to LHDs and acute care hospitals to facilitate readiness for bioterrorism and other potential threats

CHA
Mission and Vision

- Mission
  - The mission of the CHA is to work with LHDs to improve the health of all Maryland residents by preventing communicable diseases, providing public health information, protecting the health and safety of the public through education and regulation, and communicating environmental effects on public health.
- Vision
  - The CHA envisions a future in which Maryland communities organize their efforts to address the public interest in health to prevent disease and promote health.

CHA
Major Accomplishments

- Provided expert consultation to LHDs regarding 300 outbreaks and over 40,000 reports of communicable diseases
- Pilot tested new electronic communicable disease reporting system (NEDSS) for Statewide roll out in February 2006
- Vaccines for Children Program:

  - Added new meningococcal vaccine to VFC schedule for adolescents
- Accelerated timetable to Fall 2006 for grades 6-9 to be vaccinated for hepatitis B and chicken pox

CHA
Major Accomplishments

- Expanded partnerships with high school health centers and local detention centers to enhance STD screening services
- Established new partnership with State Dept. of Education to increase student awareness of STDs
- Partnered with MDA and Univ. of MD Coop. Ext. Service to provide on-farm food processing training to farmers at four sites across MD
- Revised the manual for bulk milk haulers/samplers

CHA
Major Accomplishments

- Assimilated the Office of Emergency Preparedness into the public health/ emergency preparedness and response infrastructure of the Administration
- Hurricane Katrina response

  - Assisted in deployment of 165 health professional volunteers

  - Treated over 6,200 patients at six treatment centers in Jefferson Parish between Sept. 4 – Sept. 21 2005
- Recruited over 800 new volunteers in the aftermath of hurricane Katrina

CHA
Major Accomplishments

- Developed emergency plans & conducted drills to prepare for mass vaccination clinics
- Developed surge capacity & alternative care center system providing over 7,000 beds, 3,000 volunteer providers, care centers and specialized isolation, burn and trauma treatment facilities across MD
- Trained over 300 State and local PH professionals for PH response teams
- Maintained 24/7 on-call system with physicians expert in BT agents & public health emergency mgmt.
- Implemented fully automated syndromic surveillance system in National Capital Region operational 365 days a year

CHA
Priorities

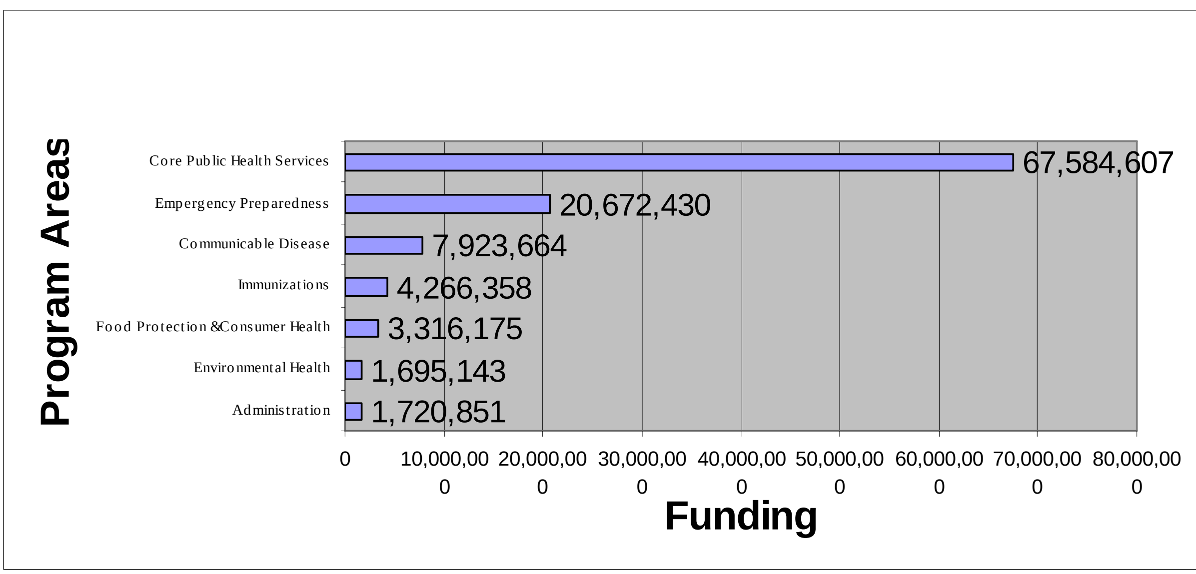
- Recruit, train and retain highly qualified staff
- Maintain high level of integrity in use and allocation of federal funds to maximize impact
- Continue to establish partnerships with other DHMH programs and State agencies on issues of mutual interest
- In partnership with MDA and LHDs, continue to provide the farming community with opportunities to offer safe food products for sale to the public

CHA
Priorities

- Improve uniformity and consistency in handling of food service issues across the various LHDs
- Integrate security considerations and evaluations into all aspects of routine inspection programs
- Work collaboratively with the newly established and separate administrative structure housing the DHMH public health/emergency preparedness and response programs and functions, including pandemic influenza planning and preparedness, previously under CHA

CHA

FY 2007 Allowance



CHA
Cost Containment Measures

- Ongoing Budgetary Pressures
  - The FY 2007 budget for Core Public Health Services reflects formula-driven funding adjustments for population and inflationary increases required by statute. However, these increases do not fully cover the rising cost of providing local public health services which are directly impacted by COLAs, higher fringe benefit rates, and other compensation-related increases not included in the formula. The budget will fund only a portion of these increased costs. We anticipate that LHDs will be hard pressed to meet service demands unless local contributions increase significantly.

CHA
Cost Containment Measures (continued)

- Staffing and funding levels have not kept pace with ever increasing workload demands
- Ongoing fiscal challenges:
  - Place the achievement of Managing for Results objectives in jeopardy
  - Underscore the need to focus our energies and resources on the most critical activities and to set aside lower priorities

CHA
Managing for Results Priorities for FY 2007

- Enhance efforts to control the number of reported cases of primary and secondary syphilis
- Maintain the high percentage of tuberculosis cases treated with directly observed therapy.
- Prevent a decrease in the percentage of 2-year olds with up-to-date immunizations.
- Prevent an increase in the percentage of closure orders issued to the following regulated entities:
  – Food firms
  – Milk/dairy farms
  – Swimming pools
  – Summer camps

Family Health Administration (FHA) *Overview*

- The Family Health Administration works to protect, promote and improve the health of all Marylanders through public health efforts, such as:
  - Maternal and child health
  - Family planning and reproductive health
  - Genetics and children with special health care needs
  - Women, Infants and Children (WIC) Program
  - Primary care and rural health
  - Prevention of chronic diseases and injury prevention
  - Oral health
  - Cancer control
  - Tobacco use prevention
  - Health policy and planning
- With federal, state and special funds, including 30 federally funded grants, FHA works with communities to assure the availability of prevention, early detection and treatment services to Marylanders.

FHA
Mission and Vision

- *Mission*
  - To protect, promote and improve the health of all Marylanders and their families through community based public health efforts, giving special attention to at-risk and vulnerable populations.
- *Vision*
  - A future in which all Marylanders and their families enjoy optimal health and well-being.
- *Strategic Approach*
  - FHA relies on the power of prevention and community-based partnerships to improve maternal and child health and prevent chronic diseases.

FHA
Major Accomplishments

- *Breast & Cervical Cancer Programs*
  - Screening program serves 14,000 persons/year
  - Diagnosis and treatment program serves 3,600 persons/year
- *Maryland WIC Program*
  - Each month 111,500 pregnant, postpartum and breastfeeding women and children up to age 5 are served
  - Network of 85 WIC clinic sites statewide
- *Maryland Family Planning Program*
  - 150,000 family planning & reproductive health visits for 75,000 low income, uninsured clients per year
  - Network of 80 clinic sites statewide
  - Serves as an entry point into the health care system that fosters health promotion and provides a broad array of preventive health services
- *Newborn screening*
  - 76,000 newborns screened and followed up for hereditary disorders and hearing impairment

FHA
Major Accomplishments

- *Clinical genetics services*
  - 7,000 individuals received counseling and case management services
- *Kids in Safety Seats*
  - 3,700 child safety seats distributed and/or inspected
- *Oral health*
  - 2,800 children received dental sealants
- *Chronic disease prevention services*
  - 30,000 clients received blood pressure and cardiovascular risk screenings
- *Tobacco use prevention*
  - 40,000 individuals received smoking cessation services and 50,000 students received tobacco use prevention education
- *Sexual assault prevention and treatment*
  - 260,000 students received sexual assault prevention education

FHA
Major Accomplishments

- *Public health systems of care and infrastructure strengthened through:*
  - *Crenshaw Perinatal Project*
    - A collaborative effort involving the Maryland Hospital Association, MIEMSS, academic centers, community-based hospitals and FHA that establishes standards for hospital perinatal care, conducts site visits, and coordinates maternal-neonatal transport.
  - *Maternal-Child Health Infrastructure*
    - Supports community-based efforts including school health, women's health, child abuse and neglect prevention/treatment, maternal mortality review, fetal and infant mortality review, and child fatality review.
  - *Early Childhood Comprehensive System*
    - Statewide partnerships with MSDE, DHR, MDE, community and faith-based organizations to develop an infrastructure that promotes the health and well-being of children and ensure children entering school ready to learn.
  - *Centers of Excellence for CSHCN*
    - Public health infrastructure for children with special health care needs is supported by this network of academic center-based pediatric specialists.

FHA
Major Accomplishments

- *Public health systems of care and infrastructure strengthened through:*
  - *Provider Capacity Building*
    - Multiple strategies designed to recruit primary care physicians, dentists, and other health care professionals through Loan Assistance Repayment Programs (LARP), J-1 Visa program, and designation of Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSAs).
  - *Community-Based Primary Prevention*
    Public information, education, peer support, coalition building, care coordination and community-based strategic planning efforts (e.g, Maryland Comprehensive Cancer Plan, Maryland Asthma Plan, and Maryland Obesity Prevention Plan) that promote healthy behaviors such as:
    - Physical activity
    - Good nutrition
    - Obesity prevention
    - Tobacco use prevention
    - Prevention of children’s environmental health problems
    - Breastfeeding promotion

FHA

Major Accomplishments

- *Public health systems of care and infrastructure strengthened through:*
  - *Public Health Surveillance*
    In the area of maternal-child health and chronic disease/injury prevention including:
    - Maryland Cancer Registry
    - Adult and Youth Tobacco Surveys
    - Behavioral Risk Factor Surveillance System (BRFSS)
    - Pregnancy Risk Assessment Monitoring System (PRAMS)
    - National Violent Data Reporting System
    - Maryland Asthma Surveillance System
    - Maryland Child Death Report

FHA
Results

- *Reduce infant mortality*
  - 22% decrease from 1992 to 2002
    - From 9.8/1000 in 1992 to 7.6/1000 in 2002
  - But a 12% increase from 2002 to 2004
    - From 7.6/1000 in 2002 to 8.5/1000 in 2004
- *Reduce teen births*
  - 32% decrease over the past 10 years
    - From 47.7/1000 in 1995 to 32.3/1000 in 2004
- *Reduce childhood lead poisoning*
  - 82% decrease in children with elevated blood lead levels over the past 9 years
    - From 9884 in 1996 to 1811 in 2004
  - 77% increase in children tested over the past 9 years
    - From 59,746 in 1996 to 105,549 in 2004
- *Reduce heart disease mortality*
  - 24% decrease over the past 10 years
    - From 277.9/100,000 in 1995 to 211/100,000 in 2004
- *Reduce cancer mortality*
  - 18% decrease over the past 10 years
    - From 230.3/100,000 in 1995 to 188.1/100,000 in 2004
- *Reduce tobacco use*
  - 30% decrease (middle school), 23% decrease (high school), 12% decrease (all adults) over past 2 years

FHA

FY 2007 Initiatives

- *Babies Born Healthy Initiative*
  - Issue
    - Infant mortality rates have worsened in recent years – the first time in 30 years that the rate has increased in 2 consecutive years.
    - A renewed effort is needed to build on the perinatal health improvement strategies that reduced infant mortality by 22% in Maryland from 1992 to 2002.
  - Complicating Factors
    - Support for the network of safety net providers (such as local health department prenatal clinics) has eroded.
    - Obstetrical providers, facing rising malpractice premiums, have taken steps to limit their practices and fewer providers are now available to meet community needs.
    - Number of uninsured/uninsurable pregnant women has increased, leading to access barriers and delays in early prenatal care.
  - Proposal
    - Prevention
      - Direct care services (preconception care, prenatal care, postpartum family planning) and enabling services (outreach, case management, home visiting) are the foundation for improving infant health.
      - Partnerships with local health department and other safety net providers will bring together the resources of Medicaid, federal Title V MCH, WIC, and other prevention programs to focus on broad public health aims.
    - Quality
      - Partnerships with Maryland Hospital Association, provider and advocacy groups will address quality improvement.
    - Data
      - Enhancement will occur through implementation of a state-of-the-art electronic birth certificate system.

FHA
FY 2007 Initiatives

- *Immigrant Health Initiative*
  - Issue
    - Access to health care is an important public health issue. Lack of health care access is an obstacle to preventive treatments and timely care for acute and chronic conditions.
  - Needs
    - Approximately 4,000 legal immigrants are in need of health care.
    - Of this population, Montgomery County (46% of pregnant women and 55% of children) and Prince George's County (36% of pregnant women and 20% of children) account for the largest number of patients.
    - Other counties with immigrant health needs, accounting for at least 1% of the target population, include Anne Arundel, Baltimore, Frederick, Harford, and Howard Counties.
  - Proposal
    - Action 1. Provide local health department grants
      - For ambulatory care to counties most affected by the health care needs of legal immigrant pregnant women and children. Because a public health infrastructure currently exists for meeting prenatal and children's primary/preventive health care for uninsured and uninsurable patients, this proposal would expand that capacity.
    - Action 2. Expand children's specialty care services
      - By providing additional funding to DHMH's Children's Medical Services fee-for-service reimbursement program that serves low income, uninsured children with chronic medical conditions.
    - Action 3. Expand other public health programs
      - Such as WIC, oral health, immunizations and other programs that serve pregnant women and children, both citizens and immigrants, in need of services. Attention to the special needs of the immigrant population, such as translation or transportation services, can be enhanced through this initiative.

Perinatal Data
Maryland and U.S., 1992-2004